



IMMEDIATE AND REMOTE THE RESULT OF SURGICAL TREATMENT OF MALIGNANT TUMORS OF THE THYROID GLAND

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Introduction

Currently, there are no absolutely reliable methods for preoperative differential diagnosis of benign and malignant thyroid tumors [1]. However, the extent of surgical intervention and the degree of its trauma depend on the correct diagnosis. If cancer is suspected, the minimum extent of intervention includes extrafascial thyroidectomy [2]. This operation can be complicated by paralysis of the recurrent laryngeal nerve and persistent hypoparathyroidism, which requires additional long-term treatment [3, 4]. All patients after thyroidectomy require hormone replacement therapy under the control of laboratory parameters and often - correction of hypocalcemia. Thus, treatment in the postoperative period is labor-intensive and requires high economic costs. At the same time, the recommended extent of intervention in the diagnosis of solid thyroid adenomas is limited to hemithyroidectomy.

The generally accepted method of preoperative diagnosis of thyroid neoplasms includes cytological and ultrasound examination (US) of material obtained using fine-needle aspiration biopsy (FNB). According to the literature, the accuracy of this method does not exceed 60% [5–7]. At the same time, the frequency of false-positive results of assessing neoplasms as malignant is the highest [8]

Material and methods. The study included 20 patients referred for surgical treatment with cytological conclusions: adenoma, follicular tumor or thyroid cancer. Instrumental and laboratory studies included the necessary preoperative minimum, thyroid ultrasound and TPB with subsequent cytological examination.



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According to international recommendations, if cancer was diagnosed at the preoperative stage, the intervention was performed in the volume of extrafascial thyroidectomy and lymph node dissection. The remaining patients underwent thyroidectomy. Due to justified oncological alertness, the volume of surgery was not limited to hemithyroidectomy in any case. The final diagnosis in all patients was established after histological examination of the removed lobes of the thyroid gland. The distribution of removed tumors by TNM at the time of discharge of patients from the hospital was as follows: T1N0M0 - 60.7%, T2N0M0 - 28.1%, T2N1M0 - 3.7%, T3N0M0 - 5.9%, T4N1M0 - 1.5%. Cancer in the right lobe was observed in 50.4%, in the left - in 43.5%, in two lobes - in 6.1%. The data we obtained coincide with the results of other authors, who note the more frequent malignant nature of tumor formations localized in the right lobe [3].

In 59.1% of cases, thyroidectomy was performed, in 14.8%, hemithyroidectomy, in 20%, subtotal resection of the thyroid gland, in the remaining 6.1% of cases, subtotal resection of one lobe and hemithyroidectomy of the other was performed (mainly for microcarcinoma, which did not require repeated surgery).

Complications in the form of laryngeal nerve paresis occurred in 8.1% of patients: 3% - bilateral, 5.1% - unilateral. In 0.7% of cases, bleeding from the wound was observed in the early postoperative period.

In conclusion, the following conclusions can be made : Three-year survival rate was 98.2%. Tumor seeding to the contralateral lobe occurred in 3% of cases, and bilateral thyroid involvement was observed in 2.2%. Radioiodine therapy was administered to 3 patients after thyroidectomy. Despite satisfactory treatment results with organ-preserving operations, we are supporters of fundamental thyroidectomy, which excludes continued tumor growth in the remaining lobe of the gland, improves the effectiveness of suppressive therapy (TG level 0.1–0.15 mIU/L), and makes it possible to carry out radioiodine therapy.

An essential condition for successful treatment of thyroid cancer is an integrated approach to solving this problem, joint work of endocrinologists, surgeons, oncologists, taking into account the recommendations adopted at the All-Russian Thyroidology Congress (2007).



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